Health Care Directive

This **Health Care Directive** is given by me,
«Client1»,
of **«City»**, **«Province»,**
on February 9, 2021.

I, «Client1», hereby declare that if the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes and directions, while I am still of sound mind.

This statement is made after careful consideration, and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out in the same way that they would be followed if I were competent and could speak for myself. I hope that my Agent(s), my family, and my doctor will regard themselves as morally bound by these provisions and I hereby absolve all who follow these instructions of any legal liability.

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1. Revocation

1.1. I revoke all former Health Care Directives, Living Wills, and Personal Directives that I have given.

2. Appointment of Agents

2.1. I appoint **«Agent1»**, to be my Proxy (hereafter referred to as my "Agent").

(a) If «Agent1» is unwilling or unable (for any reason, including disability or death) to act, or continue to act, as my Agent, I then appoint **«AltAgent1» and «AltAgent2», acting jointly, or the survivor of them,** to be my Agent.

(b) If «Agent1» and «AltAgent1» and «AltAgent2» are unwilling or unable (for any reason, including disability or death) to act, or continue to act, as my Agent(s), I then appoint **«2ndAltAgent1» and «2ndAltAgent2», acting jointly, or the survivor of them,** to be my Agent(s).

3. Effective Date of Health Care Directive

3.1. The powers given to my Agent come into effect automatically when I lose capacity, which may be evidenced by written declaration, signed by the following persons, that I am mentally incapable of managing my affairs:

(a) Two (2) licensed medical doctors or physicians; or

(b) My Agent and one (1) licensed medical doctor or physician. ; or

(c) My Agent, after consulting with a medical doctor or physician.

3.2. This Health Care Directive will continue despite any period of mental incapacity or infirmity.

3.3. Once I have become mentally incapacitated, this Health Care Directive is irrevocable during any period of my mental incapacity.

3.4. My Agent has the authority to make **emergency care** decisions on my behalf, based on my values, wishes, and beliefs expressed throughout my lifetime.

3.5. My Agent has the authority to make **serious illness care** decisions (when I am seriously ill and my doctor is uncertain of my outcome) on my behalf, based on the following guidelines:

(a) My values, wishes, and beliefs expressed throughout my lifetime;
(b) Plan Well Guide (Dear Doctor Letter) attached hereto;
(c) Any similar writings that I have made.

3.6. My Agent has the authority to make **end of life care** decisions on my behalf (when, according to my doctor, I am at or near the end of my life), based on the following guidelines:

(a) My values, wishes, and beliefs expressed throughout my lifetime;
(b) My Statement of Preferences for End of Life Care.

4. Statement of Preferences for End of Life Care

4.1. I acknowledge that I am not making any healthcare decisions today on my own behalf, but rather, I am providing the following statements to assist my Agent in making a decision when that time comes.

4.2. A 'Meaningful Recovery' should consider whether, someday, I may:

(a) be aware of my surroundings;
(b) regain some amount of higher mental function;
(c) be able to interact in a meaningful way with those around me;
(d) have the ability to look after my own basic needs.

4.3. My Agent, in consultation with my health care professionals, should assess whether there is a reasonable chance that I will have a Meaningful Recovery.

4.4. If I do not have a reasonable chance of a Meaningful Recovery, I would prefer:

(a) to die a natural death, and to avoid prolonging my life by artificial means, machines, or Cardio-Pulmonary Resuscitation (CPR).

(b) not to receive any further medical treatments, including but not limited to:

i) Hospitalization;
ii) Surgery;
iii) Invasive diagnostic testing.

(c) to receive palliative medications to ease my suffering, even though it may dull my consciousness and indirectly shorten my life.

4.5. I would prefer to live out my last days at home, rather than in a hospital, if it does not jeopardize my chance of a Meaningful Recovery, and does not place an undue burden on my family.

5. Organ Donation

5.1. I do not consent to the donation of my organs or tissue. **OR** I direct that any of my healthy organs or tissue may be donated for the following uses:

(a) for transplant purposes;
(b) for medical education;
(c) for scientific purposes.

6. Duty to Keep Records

6.1. If my Agent is not also my spouse, my Agent must:

(a) keep a record of health care decisions made by my Agent under this Health Care Directive; and

(b) keep this record during the period that I lack capacity, and retain this record for at least two (2) years after my Agent's authority ceases.

7. Compensation for The Agent

7.1. My Agent is entitled to be paid compensation for his/her time and trouble in acting as my Agent, if he/she wishes. The amount of compensation will be determined by referring to the generally accepted guidelines for compensation for trustees. OR My Agent is entitled to be reimbursed for his/her reasonable out-of-pocket expenses incurred in handling my Health Care affairs and decisions.

I make this **Health Care Directive** on February 09, 2021, at Lloydminster, Alberta.

Signed by **«Client1»**)
in the presence of:)
)
X _____)
Witness: «LwyrName»
Barrister and Solicitor

X _____
«Client1»

Affidavit of Execution

I, «LwyrName», of Lloydminster, Alberta, make oath and say that:

1. I was personally present and did see **«Client1»**, who is known to me to be the person named in the attached Health Care Directive, duly sign the instrument.

2. The instrument was signed at Lloydminster, Alberta, and I am the subscribing witness thereto.

3. I believe the person whose signature I witnessed is at least eighteen (18) years of age.

Sworn or affirmed before a Commissioner for Oaths at the city of Lloydminster, Alberta on February 9, 2021.)

_____)

«SecName»
A Commissioner for Oaths in and for the Province of Alberta,
my commission expires:
«CommExpiry»

_____

«LwyrName»

Declaration of Medical Doctor

I, _____, Medical Doctor, hereby certify that I have examined **«Client1»** the Donor named in the attached Health Care Directive, and I do hereby declare that «Client1» is:

a. Unable to understand information relevant to a health care decision respecting a proposed treatment;
and/or
b. Unable to appreciate the reasonably foreseeable consequences of making (or not making) a health care decision respecting a proposed treatment;
and/or
c. Unable to communicate a health care decision with respect to a proposed treatment.

and that the contingency (or contingencies) specified in the attached Health Care Directive has/have occurred in order to bring the Health Care Directive into effect.

Dated at _____, _____, _____.
(City/Prov) *(Date)*

_____
Name of Doctor

X _____
Signature of Doctor

_____
Name of Clinic

_____
Address of Clinic

Declaration of Medical Doctor

I, _____, Medical Doctor, hereby certify that I have examined **«Client1»** the Donor named in the attached Health Care Directive, and I do hereby declare that «Client1» is:

a. Unable to understand information relevant to a health care decision respecting a proposed treatment;
and/or
b. Unable to appreciate the reasonably foreseeable consequences of making (or not making) a health care decision respecting a proposed treatment;
and/or
c. Unable to communicate a health care decision with respect to a proposed treatment.

and that the contingency (or contingencies) specified in the attached Health Care Directive has/have occurred in order to bring the Health Care Directive into effect.

Dated at _____, _____, _____.
(City/Prov) *(Date)*

_____
Name of Doctor

X _____
Signature of Doctor

_____
Name of Clinic

_____
Address of Clinic

Declaration of Agent

I, _____, Agent for «Client1», hereby certify that I have examined **«Client1»** the Donor named in the attached Health Care Directive, and I do hereby declare that «Client1» is:

d. Unable to understand information relevant to a health care decision respecting a proposed treatment;
and/or
e. Unable to appreciate the reasonably foreseeable consequences of making (or not making) a health care decision respecting a proposed treatment;
and/or
f. Unable to communicate a health care decision with respect to a proposed treatment.

and that the contingency (or contingencies) specified in the attached Personal Directive has/have occurred in order to bring the Personal Directive into effect.

Dated at _____, _____, _____.
(City/Prov) *(Date)*

_____ **X** _____
Name of Agent Signature of Agent

_____
Address of Agent

_____

Date: February 09, 2021.

«Client1»

HEALTH CARE DIRECTIVE

Robertson Moskal Sarsons
Barristers and Solicitors
Mailing Address: P.O. Box 1680, LLOYDMINSTER, SK. S9V 1K6
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